UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ANDROGENS (all dosage forms)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Danazol® for Females:
  - only FDA-approved uses will be considered. Please submit appropriate documentation describing one of the following:
    - Hormone-responsive endometriosis
    - Trial and failure of at least one other treatment for fibrocystic breast disease
    - Trial and failure of at least one other treatment for hereditary angioedema
- Androgens for Males:
  - ≥ 19 years old
  - Diagnosis of 253.4 or 257.2
  - Symptoms of testosterone deficiency
  - Two morning testosterone levels below the individual lab's reference range (different laboratories use different assays and thus may have different ranges which are considered low, optimal, or high)

INITIAL AUTHORIZATION: 6 months

RE-AUTHORIZATION: 1 year at a time.

- Danazol® for Females: Requests must be accompanied by progress notes or a letter of medical necessity justifying continued therapy. Therapy must be for an FDA-approved use.
- Androgens for males: Requests must be accompanied by two morning testosterone levels, drawn on different days while on androgen therapy, in order to verify drug absorption. Labs drawn while off androgen therapy will not be accepted. If labs are not obtained while on androgen therapy, the patient must wait 6 months (androgen free) before re-applying for a new authorization.